




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call us at (855) 827-4448. For definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call (855) 827-4448 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <a href="#">deductible</a>?</b>	\$0 Med/ \$4,950 Rx Individual or \$0 Med/ \$9,900 Rx Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Primary Care, Specialty Care, Outpatient Mental Health, Urgent Care, Emergency Care, Lab and X-ray services, Imaging (CT/MRI/PET scans), Inpatient Hospital, Outpatient Hospital, Outpatient Surgery, PT/OT/ST, some Prescription Drugs, and Pediatric Dental and Vision are covered before the deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet deductibles for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,550 Individual or \$17,100 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://brighthouseplan.com/provider-finder/ifp">https://brighthouseplan.com/provider-finder/ifp</a> or call 1-855-827-4448 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the specialist you choose without a referral.
 All <a href="#">copayment</a> and <a href="#">coinsurance</a> costs shown in this chart are after your <a href="#">deductible</a> has been met, if a <a href="#">deductible</a> applies.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$50 per visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$100 per visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services are needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Labs: \$50 X-rays: \$100	Not Covered	Services require pre-authorization.
	Imaging (CT/PET scans, MRIs)	\$300	Not Covered	
<b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.brighthouseplan.com">www.brighthouseplan.com</a>	Generic drugs (Tier 2)	\$30 per prescription	Not Covered	Tier 1 drugs are Preventive medications that are of \$0 cost to you. Copays shown reflect the cost per retail prescription. Mail Order copays are 2.5 times the Retail cost.
	Preferred brand drugs (Tier 3)	\$200 per prescription	Not Covered	
	Non-preferred brand drugs (Tier 4)	50%	Not Covered	
	<a href="#">Specialty drugs</a> (Tier5)	50%	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$1,000	Not Covered	Services require pre-authorization.
	Physician/surgeon fees	\$300	Not Covered	
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	\$1,000	\$1,000	None

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [https://cdn1.brighthouseplan.com/docs/2021\\_COCS/COC\\_83653\\_20210101.pdf](https://cdn1.brighthouseplan.com/docs/2021_COCS/COC_83653_20210101.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention	<a href="#">Emergency medical transportation</a>	50%	50%	
	<a href="#">Urgent care</a>	\$50 per visit	\$50 per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,500	Not Covered	Copay applies per day, up to 2 days. Services require pre-authorization.
	Physician/surgeon fees	\$300	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 per visit	Not Covered	None
	Inpatient services	\$2,500 per day up to 2 days	Not Covered	Services require pre-authorization.
If you are pregnant	Office visits	No charge	Not Covered	Delivery stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean delivery require pre-authorization.
	Childbirth/delivery professional services	\$300	Not Covered	
	Childbirth/delivery facility services	\$2,500 per day up to 2 days	Not Covered	
If you need help recovering or have other special needs	<a href="#">Home health care</a>	50%	Not Covered	Limited to 60 visits per calendar year. Services require pre-authorization.
	<a href="#">Rehabilitation services</a>	\$100 per visit	Not Covered	Limited to 45 combined visits per calendar year for Occupational Therapy, Physical Therapy, Speech Therapy and Chiropractic Manipulations. Services require pre-authorization.
	<a href="#">Habilitation services</a>	\$100 per visit	Not Covered	Limited to 45 combined visits per calendar year for Occupational Therapy, Physical Therapy, Speech Therapy and Chiropractic Manipulations. Services require pre-authorization.
	<a href="#">Skilled nursing center</a>	\$2,500 per day up to 2 days	Not Covered	Limited to 60 visits per calendar year. Services require pre-authorization.

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [https://cdn1.brighthealthplan.com/docs/2021\\_COCs/COC\\_83653\\_20210101.pdf](https://cdn1.brighthealthplan.com/docs/2021_COCs/COC_83653_20210101.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	50%	Not Covered	Services require pre-authorization.
	<a href="#">Hospice services</a>	50%	Not Covered	Services require pre-authorization.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Limited to 1 eye exam per calendar year through the end of the month in which the dependent child turns 19.
	Children's glasses	No charge	Not Covered	Limited to 1 pair of glasses including standard frames and standard lenses or a one-year supply of contact lenses, per calendar year, through the end of the month in which the dependent child turns 19.
	Children's dental checkup	No charge	Not Covered	Includes diagnostic and preventive services for dependent children through the end of the month in which the dependent child turns 19. Refer to the policy for covered services and limitations.

### Excluded Services & Other Covered Services

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

Abortion (except in cases of rape, incest, or when the life of the mother is endangered) Acupuncture	Dental Care (Adults) Infertility Treatment Long Term Care	Private-duty Nursing Routine eye care (Adults) Weight loss programs
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#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

Chiropractic Care	Hearing Aids (for children)	Routine foot care (for diabetes)
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage, contact us at (855) 827-4448.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Bright Health at [www.brighthealthplan.com](http://www.brighthealthplan.com) or contact the Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089, 402-471-2201 or 877-564-7323.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al (855) 827-4448.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 827-4448.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (855) 827-4448.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (855) 827-4448.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0 Med/ \$4,950 Rx
- [Specialist](#) Copay \$100 per visit
- Hospital (facility) Copay \$2,500
- Other coinsurance 50%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$6000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6060</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0 Med/ \$4,950 Rx
- [Specialist](#) Copay \$100 per visit
- Hospital (facility) Copay \$2,500
- Other coinsurance 50%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*) Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3100
Copayments	\$900
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0 Med/ \$4,950 Rx
- [Specialist](#) Copay \$100 per visit
- Hospital (facility) Copay \$2,500
- Other coinsurance 50%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1100
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1900</b>